guidelines. However, this item is available under Optional Supplemental Benefits. See the end of Section 4 for a discussion about how you can buy Optional Supplemental Benefits.

21. Orthopedic shoes, *unless* they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under "Outpatient Medical Services").

22. Supportive devices for the feet. *There is an exception*: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under "Outpatient Medical Services").

23. Hearing aids.

24. Eyeglasses (*except* after cataract surgery), radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services. However, eyeglasses are available under the Optional Supplemental Benefits. See the end of Section 4 for a discussion about how you can buy Optional Supplemental Benefits.

25. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.

26. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)

27. Acupuncture. However, this item is available under Optional Supplemental Benefits. See the end of Section 4 for a discussion about how you can buy Optional Supplemental Benefits.

28. Naturopath services.

29. Services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under Seniority Plus, we will reimburse veterans for the difference. Members are still responsible for the Seniority Plus cost-sharing amount.

Section 6 Coverage for Outpatient Prescription Drugs

This section describes your outpatient prescription drug coverage as a member of our Plan. We will explain what a formulary is and how to use it, our drug management programs, how much you will pay when you fill a prescription for a covered drug, and what an Explanation of Benefits is and how to get additional copies.

What drugs are covered by this Plan?

What is a formulary?

We have a formulary that lists all drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail order pharmacy service and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage.

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program and both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. (See "Drug Exclusions," later in this section, for more information about the types of drugs that cannot be covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug.

Using plan pharmacies to get your prescription drugs covered by us

What are network pharmacies?

With few exceptions, **you must use network pharmacies to get your prescription drugs covered.**

- **What is a "network pharmacy"?** A network pharmacy is a pharmacy at which you can get your prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Once you go to one, you are not required to continue going to the same pharmacy to fill your prescription; you can go to any of our network pharmacies. However, if you switch to a different network pharmacy, you must either have a new prescription written by a physician or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain.

- **What are "covered drugs"?** "Covered drugs" is the general term we use to mean all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in the formulary.

How do I fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your co-payment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

The Pharmacy Directory gives you a list of Plan network pharmacies.

As a member of our Plan we will send you a Pharmacy Directory, which gives you a list of our network pharmacies. You can use it to find the network pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from Member Service. They can also give you the most up-to-date information about changes in this Plan's pharmacy network. In addition, you can find this information on our Web site.

What if a pharmacy is no longer a "network pharmacy"?

Sometimes a pharmacy might leave the plan's network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Pharmacy Directory or call Member Service to find another network pharmacy in your area.

How do I fill a prescription through Plan's network mail order pharmacy service?

You can use our network mail order pharmacy service to fill prescriptions for what we call "maintenance drugs." These are drugs that you take on a regular basis, for a chronic or long-term medical condition.

When you order prescription drugs through our network mail order pharmacy service, you must order at least a 60-day supply, and no more than a 90-day supply of the drug.

Generally, it takes us 14 days to process your order and ship it to you. However, sometimes your mail order may be delayed. If delayed and you need additional medication, please call Member Service at the telephone number listed in Section 1.

You are not required to use our mail order services to get an extended supply of maintenance medications. You can also get an extended supply through some retail network pharmacies.

Filling prescriptions outside the network

We have network pharmacies outside of the Service Area where you can get your drugs covered as a member of our plan. Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. **Before you fill your**

prescription in these situations, call Member Services to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy as any amount you pay will help you qualify for catastrophic coverage (see "Catastrophic Coverage" later in this section).

We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If you are traveling outside the Service Area and within the United States, we will cover urgent or emergency drugs.
- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (including high cost and unique drugs).
- If you are getting a vaccine that is medically necessary, but not covered by Medicare Part B and some covered drugs that are administered in your doctor's office.

How do I submit a paper claim?

When you go to a network pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

To submit a claim:

- Complete a claim form. If you need a claim form, call Member Services. You may also print a claim for from our website at www.healthnet.com.
- Attach your prescription receipt(s) to the claim form. You must attach the actual prescription receipt, a duplicate may be obtained from the dispensing pharmacy. Cash register receipts cannot be used when submitting a claim.
- Mail the completed claim form or letter and actual prescription receipt(s) to:

  Health Net of California
  Attn: Pharmacy
  P.O. Box 9103
  Van Nuys, CA 91409-9103

If you submit a paper claim to us, the claim is treated as a request for a coverage determination. If you are asking us to reimburse you for a prescription drug that is not on our formulary or is subject to coverage requirements or limits, your doctor may need to submit additional

documentation supporting your request. See Section 12 to learn more about requesting coverage determinations.

Specialty pharmacies

Home infusion pharmacies

Seniority Plus will cover home infusion therapy if:

- Your prescription drug is on our Plan's formulary or a formulary exception has been granted for your prescription drug,
- Our plan has approved your prescription for home infusion therapy, and
- Your prescription is written by an authorized prescriber.

Please refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, please contact Member Service.

Long-term care pharmacies

In some cases, residents of a long-term care facility may access their prescription drugs through the facility's long-term care pharmacy or another network long-term care pharmacy. Please refer to your Pharmacy Directory to find out if your long-term care pharmacy is part of our network. If it is not, or for more information, please contact Member Service.

Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies

Only Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through Health Net's pharmacy network. Those other than Native Americans and Alaskan Natives may be able to access these pharmacies under limited circumstances (e.g. emergencies).

Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, please contact Member Service.

How do you find out what drugs are on the formulary?

You may call Member Services to find out if your drug is on the formulary or to request a copy of our formulary. You can also get updated information about the drugs covered by us by visiting our Web site.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your co-insurance/co-payment depends on which drug tier your drug is in. The table below (under "Initial Coverage Period") shows the co-insurance/co-payment amount you pay for each tier when you are in your initial coverage period. You can ask us to make an exception (which is a type of coverage determination) to your drug's tier placement in certain circumstances. (See "Can the formulary change?" below).

Can the formulary change?

We may add or remove drugs from the formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. If we remove drugs from the formulary, or add prior authorizations, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, and you are taking the drug affected by the change, we will notify you of the change at least 60 days before the date that the change becomes effective. If we don't notify you of the change in advance, we will give you a 60 day supply of the drug when you request a refill of the drug. However, if a drug is removed from our formulary because the drug has been recalled from the market, we will not give 60-days notice before removing the drug from the formulary or give you a 60 day supply of the drug when you request a refill. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

Immediately after receiving the 60-day notice or 60-day supply, you should work with your physician to either switch to a drug we cover or request an exception (which is a type of coverage determination). If your physician determines that you need the drug that is being removed from our formulary and none of the drugs we cover are medically appropriate for you, you or your physician may request an exception. Similarly, if your physician determines that you are not able to meet a prior authorization, quantity limit, step therapy restriction, or other utilization management requirement for medical necessity reasons, you or your physician may request an exception. (See Section 12 for more information about how to request an exception.).

What if your drug is not on the formulary?

If your prescription is not listed on the formulary, you should first contact Member Services to be sure it is not covered.

If Member Services confirms that we do not cover your drug, you have three options:

- You can ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Member Services.
- You can ask us to make an exception (which is a type of coverage determination) to cover your drug. (See Section 12 for more information about how to request an exception.).
- You can pay out-of-pocket for the drug and request that the plan reimburse you by requesting an exception (which is a type of coverage determination). If the exception request is not approve the plan is not obligated to reimburse you. If the exception is not approved, you may appeal the plan's denial. (See Section 12 for more information on how to request an exception or appeal.)

If you recently joined this plan, you may be able to get a temporary supply of a drug you were taking when you joined our plan if it is not on our formulary. The next section tells the rules governing obtaining temporary supplies of drugs.

Transition Policy

New members in our plan may be taking drugs that are not on our formulary, or that are subject to certain restrictions, such as prior authorization or step therapy. Members should talk to their doctors to decide if they should switch to an appropriate drug that we cover or request a formulary exception (which is a type of coverage determination) in order to get coverage for the drug . See Section 12 to learn more about how to request an exception. While these new members might talk to their doctors to determine the right course of action, we may cover the non-formulary drug in certain cases during the first 90 days of new membership.

For each of the drugs that is not on our formulary or that have coverage restrictions or limits, we will cover a temporary 60 day supply (unless the prescription is written for fewer days) when the new member goes to a network pharmacy (and the drug is otherwise a "Part D drug"). After the first 60-day supply, we will not pay for these drugs, even if the new member has been a member of the plan less than 90 days.

If the new member is a resident of a long-term care facility, we will cover a temporary 102-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days for a new member of our plan. If a new member needs a drug that is not on our formulary or subject to other restrictions, such as step therapy or dosage limits, but the new member is past the first 90 days of new membership in our plan, we will cover a 34-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

If a member is a resident of a long-term care facility but is moving to a non-long-term care facility (e.g., home), we will cover a temporary 30-day supply. If a member is not a resident of a long-term care facility (e.g., living at home) but is moving to a long-term care setting, we will cover a temporary 34-day supply.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and that are purchased at a network pharmacy. The transition policy can not be used to purchase a non-Part D drug or drug out-of-network.

In some cases, we will contact you if you are taking a drug that is not on our formulary. We can give you the names of covered drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

Drug exclusions

By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

Nonprescription drugs	Drugs when used for anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Barbiturates and Benzodiazepines

NOTE: Due to a change in Medicare, most Medicare Drug Plans will no longer cover erectile dysfunction (ED) drugs like Viagra, Cialis, Levitra, and Caverject starting January 1, 2007. Call your Medicare Drug Plan for more information.

In addition, a Medicare Prescription Drug Plan cannot cover a drug that would be covered under Medicare Part A or Part B. (See "How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?" below.)

Also, while a Medicare Prescription Drug Plan can cover off-label uses of a prescription drug, we cover the off-label use only in cases where the use is supported by certain reference book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted.1 If the use is not supported by one of these reference books (known as compendia), then the drug would be considered a non-Part D drug and would not be covered by our plan.

Drug Management Programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed the following requirements and limits for our Plan to help us to provide quality coverage to our members:

- **Prior Authorization:** We require you to get prior authorization for certain drugs. This means that your doctor will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.

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1 These compendia are: (1) American Hospital Formulary Service Drug Information; United States Pharmacopoeia-Drug Information; and (3) the DRUGDEX Information System.

- **Quantity Limits:** For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to 6 tablets per prescription for ZITHROMAX.

- **Step Therapy:** In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.

- **Generic Substitution:** When there is a generic version of a brand-name drug available, our network pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the brand-name drug.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary. If your drug is subject to one of these additional restrictions or limits and your physician determines that you are not able to meet the additional restriction or limit for medical necessity reasons, you or your physician can request an exception (which is a type of coverage determination). (See Section 12 for more information about how to request an exception.).

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are receiving safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication therapy management programs

We offer medication therapy management programs at no additional cost for members who have multiple medical conditions, who are taking many prescription drugs, or who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We offer several medication therapy management programs for members that meet specific criteria. We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you do not need to pay anything extra to participate.

If you are selected to join a medication therapy management program, we will send you information about the specific program, including information about how to access the program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

Your enrollment in this Plan does not affect Medicare coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B even though you are enrolled in this Plan.

See your *Medicare & You* Handbook for more information about drugs that are covered by Medicare Part A and Part B.

How much do you pay for drugs covered by this Plan?

If you qualify for extra help with your drug costs, your costs for your drugs may be different than those described below. (See "What extra help is available?" later in this section and the "Evidence of Coverage Rider for those who get extra help paying for their prescription drugs" for more information.)

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., initial coverage period, after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit and your drug costs for each coverage level are described below.

Initial Coverage Period

During the **initial coverage period**, we will pay part of the costs for your covered drugs and you will pay the other part. The amount you pay when you fill a covered prescription is called the **co-insurance/co-payment**. Your co-insurance/co-payment will vary depending on the drug and where the prescription is filled.

Co-insurance/Co-payment in the Initial Coverage Period

You will have to pay the following for your prescription drugs*:

Drug Tier	Retail Co-payment/ Co-insurance (30 day supply)	Retail Co-payment/ Co-insurance (60 day supply)	Retail Co-payment/ Co-insurance (90 day Supply)	Mail-Order Co-payment/ Co-Insurance (60-day supply)	Mail-Order Co-payment/ Co-Insurance (90-day supply)	Out of Network Co-payment/ Co-Insurance (30 day supply)
Tier 1 Preferred Generic Drug	$5	$10	$15	$10	$10	$5
Tier 2 Preferred Brand Name Drug	$29	$58	$87	$58	$58	$29
Tier 3 Non-preferred Generic or Brand Name Drug	$58	$116	$174	$116	$145	$58
Tier 4 Specialty Group A (Injectables)	33%	33%	33%	33%	33%	33%
Tier 5 Specialty Group B	33%	33%	33%	33%	33%	33%

* Amounts in this chart may vary according to your individual out-of-network cost sharing responsibility.

Once your total drug costs reach $2,250, you will reach your **initial coverage limit**. Your initial coverage limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, help pay for your drugs under this plan, the amount they spend may count towards your initial coverage limit.

Coverage after you reach your Initial Coverage Limit and before your qualify for Catastrophic Coverage

After your total drug costs reach $2,250, you, or others on your behalf, will pay 100% for your drugs until your total out-of-pocket costs reach $3,850, and you qualify for catastrophic coverage.

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $3,850 out-of-pocket for the

year. When the total amount you have paid toward co-payments, and the cost for covered Part D drugs after you reach the initial coverage limit reaches $3,850 you will qualify for catastrophic coverage.

During catastrophic coverage you will pay:

> The greater of $2.15 for generics or drugs that are treated like generics and $5.35 for all other drugs, or 5% coinsurance. We will pay the rest.

What extra help is available?

Medicare provides "extra help" to pay prescription drug costs for people who meet specific income and resources limits. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for your Medicare drug plan's monthly premium, and prescription co-payments.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1. You automatically qualify for extra help and don't need to apply. If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails letters monthly to people who automatically qualify for extra help.

2. You apply and qualify. You may qualify if your yearly income is less than $14,700 (single) or $19,800 (married and living with your spouse)*, and your resources are less than $11,710 (single) or $23,410 (married and living with your spouse). Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the web, or apply at your State Medical Assistance (Medicaid) office. TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

*The above income amounts are for 2006 and will change in 2007. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How do my costs change when I qualify for extra help?

The extra help you get from Medicare will help you pay for your Medicare drug plan's monthly premium, and prescription co-payments. The amount of extra help you get is based on your income and resources.

If you qualify for extra help, we will send you by mail an "Evidence of Coverage Rider for those who receive extra help from Medicare for their prescription drugs" that explains your costs as a

member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for those who receive extra help from Medicare for their prescription drugs".

How do you get more information?

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.socialsecurity.gov on the Web. TTY/TDD users should call 1-800-325-0778.

In addition, you can look at the 2007 *Medicare & You* Handbook, visit www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you have any questions about our Plan, please refer to our Member Services numbers listed on the cover and in the Benefits at a Glance section. Or, visit our website.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs can count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug you are paying for is a Part D drug, on the formulary (or if you get a favorable decision on a coverage determination, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy); and otherwise meets our coverage requirements:

- Your co-insurance or co-payments; payments you make after the initial coverage limit.

When you have spent a total of $3,850 for these items, you will reach the catastrophic coverage level. The amount you pay for your monthly premium does not count toward reaching the catastrophic coverage level.

Purchases that will **not** count toward your out-of-pocket costs include:

Prescription drugs purchased outside the United States and its territories;

Prescription drugs not covered by the Plan

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Except for your premium payments, any payments you make for Part D drugs covered by us count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs (and will help you qualify for catastrophic coverage):

Family members or other individuals;

Qualified State Pharmacy Assistance Programs (SPAPs);

Medicare programs that provide extra help with prescription drug coverage; and

Most charities or charitable organizations. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following do **not** count toward your out-of-pocket costs:

Group Health Plans;

Insurance Plans and government funded health programs (e.g. TRICARE, the VA, the Indian Health Service); and

Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers Compensation).

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must disclose this information to us.

We will be responsible for keeping track of your out-of-pocket cost amount and will let you know when you have qualified for catastrophic coverage. If you or another party on your behalf have purchased drugs outside of our plan benefit, you will be responsible for submitting appropriate documentation of such purchases to us. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your drugs. You will get your Explanation of Benefits in the mail each month that you use the benefits provided by us. You will not get an Explanation of Benefits if you don't use any benefits that month.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
- Information about how to request an exception and appeal our coverage decisions;
- A description of changes to the formulary affecting the prescriptions you filled that will occur at least 60 days in the future;
- A summary of your coverage this year, including information about:
- **Annual Deductible** -the amount you pay, and/or others, before you start receiving prescription coverage.

- **Amount Paid For Prescriptions** -the amounts paid that count towards your initial coverage limit.
    - **Total Out-Of-Pocket Costs That Count Towards Catastrophic Coverage** -The total amount you and/or others have spent on prescription drugs that count towards you qualifying for catastrophic coverage. This total includes the amounts spent for your co-payments and co-insurance, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount does not include payments made by your current or former employer/union, another insurance plan or policy, government funded health program or other excluded parties.)

What should you do if you did not get an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To get a copy, please contact Member Services.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, Medicare Part A will cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we will cover your prescription drugs as long as all coverage requirements are met (such as the drugs being on our formulary, filled at a network pharmacy, etc.), they are not covered by Medicare Part A or Part B, are part of the formulary and are purchased at one of our network pharmacies. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, after Medicare Part A stops paying for your prescription drug costs, we will cover your prescriptions as long as the drug meets all of our coverage requirements (including the requirement that the skilled nursing facility pharmacy be in our pharmacy network, unless you meet standards for out-of –network care, and that the drug would not otherwise be covered by Medicare Part B coverage). When you enter, live in, or leave a skilled nursing facility you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Prescription Drug Plan. (Please see Section 13 of this document for more information about leaving this Plan and joining a new Medicare Prescription Drug Plan.)

Section 7 Hospital care, skilled nursing facility care, and other services (this section gives additional information about some of the covered services that are listed in the Benefits Chart in Section 4)

Hospital care

If you need hospital care, we will arrange covered services for you. Covered services are listed in the Benefits Chart in Section 4 under the heading "Inpatient Hospital Care." We use "hospital" to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term "hospital" does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

See Section 17 for definition of Inpatient care.

In order for Health Net Seniority Plus to cover hospital care, you must use a plan hospital. Services will not be covered if you are admitted into a non-plan hospital, except in an emergency.

Your Health Net contracting Medical Group has one or more local plan hospitals to choose from. Your selected PCP and Health Net contracting Medical Group will coordinate your care and admit you to a plan hospital for inpatient and outpatient care.

What is a "benefit period" for hospital care

Seniority Plus uses benefit periods to determine your coverage for inpatient services during a hospital stay (generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital). A "**benefit period**" begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility (SNF). The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. (Later in this section we explain about SNF services)

What happens if you join or drop out of Seniority Plus during a hospital stay?

If you either join or leave Seniority Plus during an inpatient hospital stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Member Services at the telephone number listed in Section 1. Member Services can explain how your services are covered for this stay, and what you owe to providers, if anything, for the periods of your stay when you were and were not a Plan Member.

Skilled nursing facility care (SNF care)

If you need skilled nursing facility care, we will arrange these services for you. Covered services are listed in the Benefits Chart in Section 4 under the heading "Skilled nursing facility care." The purpose of this subsection is to tell you more about some rules that apply to your covered services.

A skilled nursing facility is **a place that provides skilled nursing or skilled rehabilitation services**. It can be a separate facility, or part of a hospital or other health care facility. A Skilled Nursing Facility is called a "SNF" for short. The term "skilled nursing facility" does not include places that mainly provide custodial care, such as convalescent nursing homes or rest homes. (By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.)

What is skilled nursing facility care?

"Skilled nursing facility care" means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities such as eating and dressing by yourself.

To be covered, the care you get in a SNF must meet certain requirements

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF.

Stays that provide custodial care only are not covered

"Custodial care" is care for personal needs rather than Medically Necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by Seniority Plus unless it is provided as other care you are getting *in addition to* daily skilled nursing care and/or skilled rehabilitation services.

There are Benefit period limitations on coverage of skilled nursing facility care

Inpatient skilled nursing facility coverage is limited to 100 days each Benefit period. A "**Benefit period**" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The Benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one Benefit period has ended, a new Benefit period begins. There is no limit to the number of Benefit periods you can have.

Please note that after your SNF day limits are used up, physician services and other medical services will still be covered. These services are listed in the Benefits Chart in Section 4 under the heading, "Inpatient services (when the hospital or SNF days are not or are no longer covered)."

In some situations, you may be able to get care in a SNF that is not a plan provider

Generally, you will get your skilled nursing facility care from SNFs that are plan providers for Seniority Plus. However, *if certain conditions are met*, you may be able to get your skilled nursing facility care from a SNF that is not a plan provider. One of the conditions is that the SNF that is not a plan provider must be willing to accept Health Net's rates for payment. At your request, we may be able to arrange for you to get your skilled nursing facility care from one of the facilities listed below (in these situations, the facility is called a "Home SNF"):

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

What happens if you join or drop out of Seniority Plus during a SNF stay?

If you either join or leave Seniority Plus during a SNF stay, please call Member Services at the telephone number listed in Section 1. Member Services can explain how your services are covered for this stay, and what you owe to Health Net, if anything, for the periods of your stay when you were and were not a Plan Member.

Home health agency care

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 4 under the heading "Home health care." If you need home health care services, we will arrange these services for you if the requirements described below are met.

What are the requirements for getting home health agency services?

To get home health agency care benefits, you must meet all of these conditions:

1. You must be **home-bound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.

   Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. "Supportive devices" include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.

2. Your doctor must decide that you need medical care in your home, and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.
3. The home health agency caring for you must be approved by the Medicare program.
4. You must need *at least one* of the following types of skilled care:

   - Skilled nursing care on an "intermittent" (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
   - Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheel chair or bathtub.
   - Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
   - Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

Home health care can include services from a home health aide, as long as you are also getting skilled care

As long as some qualifying skilled services are *also* included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license. The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or injury, and they are not covered unless you are *also* getting a covered skilled service. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

What are "part time" and "intermittent" home health care services?

If you meet the requirements given above for getting covered home health services, you may be eligible for "part time" or "intermittent" skilled nursing services and home health aide services:

- **"Part-time" or "Intermittent"** means your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

Hospice care for people who are terminally ill

"Hospice" is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

As a Member of Seniority Plus, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call Member Services at the number in Section 1 to get a list of the Medicare-certified hospice providers in your area or you can call **1-800-MEDICARE** (**1-800-633-4227**; TTY **1-877-486-2048**) to receive help obtaining the list. (If you are enrolled in Medicare Part B only and not entitled to Part A, you should call Members Services at the telephone number in Section 1, to get information on your hospice coverage.)

If you enroll in a Medicare-certified hospice, Original Medicare (rather than Seniority Plus) pays the hospice for the hospice services you receive. Your hospice doctor can be a plan provider or a non-plan provider. If you choose to enroll in a Medicare-certified hospice, you are still a Plan Member and continue to get the rest of your care that is unrelated to your terminal condition through Seniority Plus. If you use non-plan providers for your routine care, Original Medicare (rather than Seniority Plus) will cover your care and you will have to pay Original Medicare out-of-pocket amounts.

The Medicare program has written a booklet about "Medicare Hospice Benefits." To get a free copy call **1-800-MEDICARE** (**1-800-633-4227**; TTY **1-877-486-2048**), which is the national Medicare help line, or visit the Medicare website at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about the website.

Please inform us before you start a clinical trial so that we may track your health care services. You do not need to get a referral from a plan provider to join a clinical trial. Similarly, the clinical trial providers do not need to be plan providers.

Organ transplants

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others are not). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas, liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: kidney, heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

Participating in a clinical trial

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe.

Medicare pays for routine costs if you take part in a clinical trial that meets Medicare requirements. Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare (and not Seniority Plus) pays the clinical trial doctors and other providers for the covered services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in Seniority Plus and continue to get the rest of your care that is unrelated to the clinical trial through Seniority Plus.

You will have to pay Original Medicare co-insurance for the services you receive when participating in a qualifying clinical trial. You do not have to pay the Original Medicare Part A or Part B deductibles, because you are enrolled in Seniority Plus. For instance, you will be responsible for Part B co-insurance -- generally 20% of the Medicare-approved amount for most doctor services and most other outpatient services. However, there is no co-insurance for Medicare-covered clinical laboratory services related to the clinical trial. The Medicare program has written a booklet that includes information on Original Medicare co-insurance rules, called "Medicare & You." To get a free copy, call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048) or visit www.medicare.gov on the web.

The Medicare program has written a booklet about "Medicare and Clinical Trials." To get a free copy, call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048) or visit www.medicare.gov on the web. Section 1 tells more about how to contact the Medicare program and about Medicare's website.

You do *not* need to get a referral from a plan provider to join a clinical trial, and the clinical trial providers do *not* need to be plan providers. However, please be sure to **tell us before you start a clinical trial** so that we can keep track of your health care services. When you tell us about starting a clinical trial, we can let you know what services you will get from clinical trial providers and what your costs for those services will be.

Care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by Seniority Plus under certain conditions. Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services, or care in a home health agency. You may get services when furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. "Non-excepted" medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from Health Net, or your stay in the RNHCI may not be covered.

Section 8 What you must pay for your Medicare health plan coverage and for the care you receive

Paying the plan premium for your coverage as a Member of Seniority Plus

To be a Member of Seniority Plus, you must continue to pay your Medicare Part B premium. If you have to pay a Medicare Part A premium (most people do not), you must continue paying that premium to be a member. You also have Seniority Plus premiums that you must pay.

How much is your monthly plan premium and how do you pay it?

If you signed up for extra benefits (these are called "optional supplemental benefits"), you will have to pay a plan premium each month for these extra benefits. For more information on these extra benefits and how much they cost, please contact Member Services at the number in Section 1.

In Seniority Plus, you must pay a $100 premium each month. This monthly plan premium covers your basic benefits. If you signed up for extra benefits (these are called "optional supplemental benefits"), you will have to pay an additional premium each month for these extra benefits. For more details, please see Section 4. Seniority Plus offers three methods for paying your monthly plan premiums. You can use one of these methods to pay your plan premium for basic benefits and any other premiums that you may owe Health Net, such as premiums for optional supplemental benefits. These methods for paying your premiums are called automatic bank draft, monthly coupon payment or statement. If you are interested in any of these methods, please call the Seniority Plus Member Services Department for the appropriate forms.

If you have any questions about your plan premiums or the payment programs, please call Member Services at the number in Section 1.

The monthly plan premium is due to Health Net Seniority Plus by the first of every month.

Please note, a $15 fee will be assessed for all returned checks.

What happens if you don't pay your plan premiums, or don't pay them on time?

If your plan premiums are past due, we will tell you in writing when a 90-day grace period begins. If you do not pay your past-due plan premiums within the 90-day grace period, we will disenroll you. Disenrolling you ends your membership in Health Net. You will then have Original Medicare coverage (Section 12 explains about disenrollment and Original Medicare coverage). Should you decide later to re-enroll in Seniority Plus, or to enroll in another plan offered by Health Net, you will have to pay any past-due plan premiums that you still owe from your previous enrollment in Seniority Plus.

If you signed up for extra benefits ("optional supplemental benefits"), and you do not pay the additional premium for these extra benefits, we will tell you in writing when a 90-day grace period

begins. If you do not pay your past-due premiums for these extra benefits within the 90-day grace period, we will no longer cover the extra benefits.

Paying your share of the cost when you get covered services

What are "co-payments" and "co-insurance"?

- A **"co-payment"** is a payment you make for your share of the cost of certain covered services you receive. A co-payment is **a set amount per service** (such as paying $50 for each Medicare-covered emergency room visit, unless you are admitted to the hospital). You pay it when you get the service. The Benefits Chart in Section 4 gives your co-payments for covered services. Section 6 gives your copayments for prescription drugs.
- **"Co-insurance"** is a payment you make for your share of the cost of certain covered services you receive. Co-insurance is **a *percentage* of the cost of the service** (such as paying 20% of the cost for Durable Medical Equipment). You pay your co-insurance when you get the service. The Benefits Chart in Section 4 gives your co-insurance for covered services. Section 6 gives your coinsurance for prescription drugs.

You must pay the full cost of services that are not covered

You are personally responsible to pay for care and services that are not covered by Seniority Plus. Other sections of this booklet tell about covered services and the rules that apply to getting your care as a Plan Member. With few exceptions, you must pay for services you receive from providers who are not part of Seniority Plus unless Health Net has approved these services in advance. The exceptions are care for a medical emergency, urgently needed care, out-of-area renal (kidney) dialysis services, and services that are found upon appeal to be services that we should have paid or covered. (Sections 2 and 3 explain about using plan providers and the exceptions that apply.)

For covered services that have a benefit limitation, **you must pay the full cost of any services you get after you have used up your benefit for that type of covered service.** For example, you have to pay the full cost of any emergency service outside of the United States once you reach your yearly $50,000 benefit limit. You can call Member Services when you want to know how much of your benefit limit you have already used.

Please keep us up-to-date on any other health insurance coverage you have

Using *all* of your insurance coverage

If you have other health insurance coverage besides Seniority Plus, it is important to use this other coverage *in combination with* your coverage as a member to pay for the care you receive. This is called "coordination of benefits" because it involves *coordinating* all of the health *benefits* that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

Let us know if you have additional insurance

You must tell us if you have any other health insurance coverage besides Seniority Plus, and let us know whenever there are any *changes* in your additional insurance coverage. The types of additional insurance you might have include the following:

- Coverage that you have from an employer's group health insurance for *employees* or *retirees*, either through yourself or your spouse.
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.
- Coverage you have through the "TRICARE for Life" program (veteran's benefits).
- Coverage you have for dental insurance or prescription drugs.
- "Continuation coverage" that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

Who pays first when you have additional insurance?

How we coordinate your benefits as a Member of Seniority Plus with your benefits from other insurance depends on your situation. If you have other coverage, you will often get your care as usual through Seniority Plus, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by Seniority Plus, you may get your care outside of Seniority Plus.

The insurance company that pays its share of your bills *first* is called the "**primary payer**." Then the other company or companies that are involved – called the "**secondary payers**" – each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional health insurance, **whether we pay first or second – or at all – depends on what type or types of additional insurance you have and the rules that apply to your situation**. Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer's group insurance.

If you have additional health insurance, please call Member Services at the phone number on the cover of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other*

Health Benefits: Your Guide to Who Pays First. You can get a copy by calling **1-800-MEDICARE** (**1-800-633-4227**; TTY **1-877-486-2048**), or by visiting the www.medicare.gov website.

What should you do if you have bills from non-plan providers that you think we should pay?

As explained in Sections 2 and 3, we cover certain health care services that you get from non-plan providers. These include care for a medical emergency, urgently needed care, renal dialysis that you get when you are outside the plan's Service Area, care that has been approved in advance by Health Net, and services that we denied but that were overturned in an appeal. If a non-plan provider asks you to pay for covered services you get in these situations, please contact us at:

Health Net Seniority Plus
Member Services Department
Post Office Box 10198
Van Nuys, CA 91410-0198

All Foreign or Cruise Claims must be mailed to:
Health Net Seniority Plus
"Attention: Foreign Claims"
Post Office Box 10198
Van Nuys, CA 91410-0198

It is best to ask a non-plan provider to bill us first, but if you have already paid for the covered services we will reimburse you for our share of the cost. If you received a bill for the services, you can send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You will not have to pay a non-plan provider any more than what he or she would have received from you if you had been covered with Original Medicare.

Section 9 Your rights and responsibilities as a Member of Seniority Plus

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this Section, we explain your Medicare rights and protections as a Member of Seniority Plus. We explain what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**. You can call 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. Health Net must obey laws that protect you from discrimination or unfair treatment. These laws do not allow us to discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability. If you need help with communication, such as help from a language interpreter, please call Member Services at the number shown in Section 1. Member Services can also help if you need to file a complaint about access (such as wheel chair access). You can also call the Office of Civil Rights at **1-800-368-1019** or TTY/TDD **1-800-537-7697**, or, call the Office For Civil Rights in your area.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask plan providers to make additions or corrections to your medical records (if you ask plan providers to do this, they will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have

questions or concerns about privacy of your personal information and medical records, please call Member Services at the phone number in Section 1.

Your right to see plan providers, get covered services, and get your prescriptions filled within a reasonable period of time

As explained in this booklet, you will get most or all of your care from plan providers, that is, from doctors and other health providers who are part of Seniority Plus. You have the right to choose a plan provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. You also have the right to timely access to your prescriptions at any network pharmacy. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use plan providers to get the care and services you need. Section 3 explains your rights to get care for a medical emergency and urgently needed care.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment choices that are recommended for your condition, no matter what they cost or whether they are covered by Seniority Plus. This includes the right to know about the different Medication Management Treatment Programs we offer and which you may participate. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a plan provider has denied care that you believe you are entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision. "Initial decisions" are discussed in Sections 10 and 11.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone you trust the legal authority to make decisions for you if you ever become unable to

make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "**advance directives.**" There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as HICAP. Section 1 of this booklet tells how to contact HICAP. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you *have* signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with the California Department of Health Services, P.O. Box 997413, M.S. 3200, Sacramento, California 95899-7413. The telephone number for the California Department of Health Services is **1-800-236-9747** (TTY **1-916-440-7399**).

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. The complaint is called an appeal or grievance depending on the situation. Appeals and grievances that involve that involve your Medicare health benefits under Seniority Plus are discussed in Sections 10 and 11, Appeals and grievances that involve the Seniority Plus drug benefit are discussed in section 10 and 12.

If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed *against* Health Net in the past. To get this information, call Member Services at the phone number shown in Section 1.

Your right to get information about your health care coverage and costs

This booklet tells you what medical services are covered for you as a Plan Member and what you have to pay. If you need more information, please call Member Services at the number shown in Section 1. You have the right to an explanation from us about any bills you may get for services not covered by Seniority Plus. We must tell you in writing why we will not pay for or allow you to get a service, and how you can file an appeal to ask us to change this decision. See Sections 10 and 11 for more information about filing an appeal.

Your right to get information about Health Net, Seniority Plus, plan providers, your drug coverage, and costs

You have the right to get information from us about Health Net and Seniority Plus. This includes information about our financial condition, about our health care providers and their qualifications, and about how Seniority Plus compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Member Services at the phone number shown in Section 1. You have the right to get information from us about Health Net and Part D. This includes information about our financial condition and about our network pharmacies. To get any of this information, call Member Services at the phone number listed in Section 1.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Member Services at the number shown in Section 1. You can also get free help and information from HICAP (Section 1 tells how to contact HICAP). In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections.* To get a free copy, call **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov on the web to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. Or, you can call the Office of Civil rights at **1-800-368-1019** or TTY/TDD **1-800-537-7697**, or, call the Office of Civil Rights in your area.

- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Member Services at the number shown in Section 1. You can also get help from HICAP (Section 1 tells how to contact HICAP).

What are your responsibilities as a Member of Seniority Plus?

Along with the rights you have as a Member of Seniority Plus, you also have some responsibilities. Your responsibilities include the following:

- To get familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Member Services at the phone number shown in Section 1 if you have any questions.
- To give your doctor and other providers the information they need to care for you, and to follow the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and to explain your treatment in a way you understand.
- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- To pay your plan premiums and any co-payments you owe for the covered services you get. You must also meet your other financial responsibilities that are described in Section 8 of this booklet.
- To let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services at the phone number shown in Section 1.

Section 10 How to file a grievance

What is a Grievance?

A grievance is different from a request for an organization determination, a request for a coverage determination, or a request for an appeal as described in Section 11 and Section 12 of this Evidence of Coverage because grievances do not involve problems related to coverage or payment for care or Part D benefits, problems about being discharged from the hospital too soon, and problems about coverage for Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation (CORF) services ending too soon.

For problems about coverage or payment for care, problems about being discharged from the hospital too soon, and problems about coverage for SNF, HHA, or CORF services ending too soon, you must follow the rules outlined in Section 11.

If you have a problem about our failure to cover or pay for a Part D prescription drug, you must follow the rules outlined in Section 12.

What types of problems might lead to you filing a grievance?

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) Seniority Plus.
- Problems with the Member Service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, in a network pharmacy, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, network pharmacists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, network pharmacists, or hospitals.
- If you disagree with our decision not to expedite your request for an expedited coverage determination, organization determination, redetermination, or reconsideration.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required timeframe.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.

- Failure by the Plan to provide required notices.
- Failure to provide required notices that comply with CMS standards.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In certain cases, you have the right to ask for a "fast grievance," meaning your grievance will be decided within 24 hours. We discuss these fast grievances in more detail in Section 11 and Section 12.

Filing a grievance with Health Net

If you have a complaint, we encourage you to first call Member Services at the number shown in Section 1. We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the Grievance procedure.**

To make a complaint, or if you have questions about this procedure, please call the Health Net Seniority Plus Member Service Department at **1-800-275-4737** (TTY/TTD **1-800-929-9955**).

You may also submit your complaint in writing or via facsimile to Health Net at:

Health Net Seniority Plus
Appeals & Grievances Department
Post Office Box 10344
Van Nuys, CA 91410-0344

Fax: **1-818-676-8179**

You need to file your complaint within 60 calendar days after the event. We can give you more time if you have a good reason for missing the deadline.

Expedited Grievance Procedure

You are now entitled to a quick review of your complaint if you disagree with our decision in the following circumstances:

- We deny your request for a fast review of a request for medical care
- We deny your request for a fast review of an appeal of denied services.
- We decide additional time is needed to review your request for medical care.
- We decide additional time is needed to review your appeal of denial medical care.

Requests for Expedited Grievances may be submitted telephonically at **1-800-275-4737** (TTY/TDD **1-800-929-9955**). You may also submit your complaint in writing or via facsimile to Health Net at:

Health Net Seniority Plus
Appeals and Grievance Department
Post Office Box 10344
Van Nuys, CA 91410-0344

Fax: **1-818-676-8179**

Once the Expedited Grievance is received by Health Net, a Clinical Practitioner will review the case to determine the circumstances surrounding the denial of your request for expedited review or if the case extension was appropriate.

You will be notified of the outcome of the Expedited Grievance case verbally and in writing within 24 hours of initial receipt of the case.

Complaints about a decision regarding payment for, or provision of, Covered Services that you believe are covered by Original Medicare and should be provided or paid for by Health Net must be appealed through Health Net's Medicare Appeals procedure.

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care problems, you may also complain to Lumetra (Quality Improvement Organization – QIO)

Complaints concerning the quality of care received under Medicare, including care during a hospital stay, may be acted upon by the plan sponsor under the grievance process, by an independent organization called Lumetra, or by both. For any complaint filed with Lumetra, the plan sponsor must cooperate with Lumetra in resolving the complaint. See Section 1 for more information about the QIO.

How to file a quality of care complaint with Lumetra

Quality of care complaints filed with Lumetra must be made in writing. An enrollee who files a quality of care grievance with Lumetra is not required to file the grievance within a specific time period. See page 3 of the introduction for more information about how to file a quality of care complaint with Lumetra.

Section 11 Information on how to make a complaint about Part C medical services and benefits

Introduction

This section gives the rules for making complaints about Part C services and payments in different types of situations. **Note: please see Section 12 for complaints about prescription drugs (Part D).** Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a Plan Member. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from Seniority Plus or penalized in any way if you make a complaint.

Please refer to Original Medicare in Section 8 of your 2007 *Medicare and You Handbook* for additional guidance on your appeal rights under Original Medicare. If you do not have a *Medicare and You Handbook,* please call *1-800 Medicare* to get a copy.

How to make complaints in different situations

This section tells you how to complain about services or payment in each of the following situations:

Part 1. Complaints about what benefit or service we will provide you or what we will pay for (cover).

Part 2. Complaints if you think you are being discharged from the hospital too soon.

Part 3. Complaints if you think your coverage for skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services is ending too soon.

If you want to make a complaint about any type of problem other than those that are listed above, a **grievance** is the type of complaint you would make. **For more information about grievances, including how to file a grievance, see Section 10.**

PART 1. COMPLAINTS ABOUT WHAT BENEFIT OR SERVICE HEALTH NET WILL PROVIDE YOU OR WHAT HEALTH NET WILL PAY FOR (COVER)

What are "complaints about your services or payment for your care?"

If you are not getting the care you want, and you believe that this care is covered by Seniority Plus.

- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by Seniority Plus.

- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- If you have received care that you believe should be covered by Seniority Plus, but we have refused to pay for this care because we say it is not covered.

What is an organization determination?

An organization determination is our initial decision about whether we will provide the medical care or service you request, or pay for a service you have already received. If our initial decision is to deny your request, you can **appeal** the decision by going on to Appeal Level 1 (see below). You may also appeal if we fail to make a timely initial decision on your request.

When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of Seniority Plus apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by Seniority Plus, including any limitations that may apply to these services. This booklet also lists exclusions (services that are "not covered" by Seniority Plus).

Who may ask for an "initial decision" about your medical care or payment?

Depending on the situation, your doctor or other medical provider may ask us whether we will authorize the treatment. Otherwise, you can ask us for an initial decision yourself, or you can name (appoint) someone to do it for you. This person you name would be your representative. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under state law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your representative. This statement must be sent to us at Health Net Medical Management Department, 155 Grand Avenue, Suite #5000, Oakland, CA 94612. You can call us at **1-800-977-7282** (TTY/TDD **1-800-929-9955**) to learn how to name your representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to contact HICAP at **1-858-565-8772** or **1-800-434-0222.** TTY/TDD users should call the California Relay Service at **711** or **1-800-735-2929**. Calls to these numbers are free.

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days), or it can be a "fast decision" that is made more quickly (typically within 72 hours). A fast decision is sometimes called an "expedited organization determination."

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

Asking for a standard decision

To ask for a standard decision about providing medical care or payment for care, you or your representative should mail or deliver a request in writing to the following address: Health Net Medical Management, 155 Grand Avenue, Suite #5000, Oakland, CA 94612.

Asking for a fast decision

You, any doctor, or your representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling us **1-800-977-7282** (for TTY, call **1-800-929-9955**). Or, you can deliver a written request to Health Net Medical Management, 155 Grand Avenue, Suite #5000, Oakland, CA 94612, or fax it to **1-800-793-4473** (elective requests) or **1-800-672-2135** (urgent requests). Be sure to ask for a "fast" or "72-hour" review. Requests received after business hours are handled on the next business day. To reach us after our regular business hours, please fax us at **1-800-793-4473** (elective requests) or **1-800-672-2135** (urgent requests).

If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a "fast" decision, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a "fast grievance." If we deny your request for a fast decision, we will give you a standard decision. For more information about grievances, see Section 10.

What happens next when you request an initial decision?

1. *For a decision about payment for care you already received.*

We have 30 days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing if we extend the timeframe for making a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 days of your request, you can **appeal** this decision. (An appeal is also called a "reconsideration.")

2. *For a standard initial decision about medical care.*

We have 14 days to make a decision after we have received your request. However, we can take up to 14 more days if you request the additional time, or if we need more time to gather information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a "fast grievance" (see Section 10).

If we do not approve your request, we must explain why in writing, and tell you of your right to appeal our decision.

If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

3. *For a fast initial decision about medical care.*

If you receive a "fast" decision, we will give you our decision about your medical care within 72 hours after you or your doctor ask for it – sooner if your health requires. However, we can take up to 14 more days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you believe that we should not take any additional days, you can file a fast grievance.

We will tell you our decision by phone as soon as we make the decision. If we deny any part of your request, we will send you a letter that explains the decision within 3 days of contacting you by phone. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a fast grievance.

Appeal Level 1: If we deny any part of your request for coverage or payment of a service, you may ask us to reconsider our decision. This is called an "appeal" or a "request for reconsideration."

Please call us at **1-800-275-4737** (TTY/TDD **1-800-929-9955**) if you need help in filing your appeal. We give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

If your appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a "fast" appeal. The procedures for deciding on a "standard" or a "fast" *appeal* are the same as those described for a "standard" or "fast" *initial decision*. While the process for deciding on a standard or fast appeal are the same as the process for a standard or fast decision, the place where the appeal is sent is different, please refer to "What if you want a 'fast' appeal" later in this section for more information.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get the doctor's records or the doctor's opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to Health Net Seniority Plus, Appeals and Grievance Department, Post Office Box 10344, Van Nuys, California 91410-0344.

- By fax, at **1-818-676-8179**.
- By telephone – if it is a "fast appeal" – at **1-800-275-4737** (TTY/TDD **1-800-929-9955**).
- In person, at 21281 Burbank Boulevard, Woodland Hills, California 91367.

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at **1-800-275-4737** (TTY/TDD **1-800-929-9955**), Health Net Seniority Plus, Appeals and Grievance Department, Post Office Box 10344, Van Nuys, California 91410-0344.

How do you file your appeal of the initial decision?

The rules about who may file an appeal are the same as the rules about who may ask for an initial decision. Follow the instructions under "Who may ask for an 'initial decision' about medical care or payment?" However, providers who do not have a contract with Health Net must sign a "waiver of payment" statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

You need to file your appeal within 60 days after we notify you of the initial decision. We can give you more time if you have a good reason for missing the deadline. To file an appeal, you can send the appeal to us in writing at Health Net Seniority Plus, Appeals and Grievance Department, Post Office Box 10344, Van Nuys, California 91410- 0344

What if you want a "fast" appeal?

The rules about asking for a "fast" appeal are the same as the rules about asking for a "fast" initial decision. The process for deciding on a standard or fast appeal are also the same as the process for a standard or fast decision. You can call us at **1-800-275-4737** (for TTY, call **1-800-929-9955**). Or, you can deliver a written request to Seniority Plus, Appeals and Grievance Department, Post Office Box 10344, Van Nuys, California 91410-0344, or fax it to **1-818-676-8179**. Requests received after business hours are handled on the next business day. Be sure to ask for a "fast," "expedited," or "72-hour" review.

How soon must we decide on your appeal?

1. *For a decision about payment for care you already received.*

   After we receive your appeal, we have 60 days to make a decision. If we do not decide within 60 days, your appeal *automatically* goes to Appeal Level 2.

2. *For a standard decision about medical care.*

   After we receive your appeal, we have up to 30 days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will *automatically* go to Appeal Level 2.

3. *For a fast decision about medical care.*

After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will *automatically* go to Appeal Level 2.

What happens next if we decide completely in your favor?

1. *For a decision about payment for care you already received.*

   We must pay within 60 calendar days of the day we received your request for us to reconsider our initial decision.

2. *For a standard decision about medical care.*

   We must authorize or provide you with the care you have asked for no later than 30 days after we received your appeal. If we extend the time needed to decide your appeal, we will authorize or provide your medical care when we make our decision.

3. *For a fast decision about medical care.*

   We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal – or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize or provide your medical care at the time we make our decision.

What happens next if we deny your appeal?

If we deny any part of your appeal, your appeal *automatically* goes on to Appeal Level 2 where an independent review organization will review your case. This organization contracts with the federal government and is not part of Health Net. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the organization depends on the type of appeal:

1. *For a decision about payment for care you already received.*

   We must send all the information about your appeal to the independent review organization within 60 days from the date we received your Level 1 appeal.

2. *For a standard decision about medical care.*

   We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 days after we received your Level 1 appeal.

3. *For a fast decision about medical care.*

   We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

Appeal Level 2: If we deny any part of your Level 1 appeal, your appeal will automatically be reviewed by a government-contracted independent review organization

At the second level of appeal, your case is given a new review by an outside, independent review organization that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program. This organization has no connection to us. We will tell you when we have sent your appeal to this organization. You have the right to get a copy from us of your case file that we sent to this organization.

How soon must the independent review organization decide?

1. *For an appeal about payment for care,* the independent review organization has up to 60 days to make a decision.
2. *For a standard appeal about medical care,* the independent review organization has up to 30 days to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.
3. *For a fast appeal about medical care,* the independent review organization has up to 72 hours to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it.

1. *For an appeal about payment for care,*

   We must pay within 30 days after receiving the decision.

2. *For a standard appeal about medical care,*

   We must *authorize* the care you have asked for within 72 hours after receiving notice of the decision, or *provide* the care no later than 14 days after receiving the decision.

3. *For a fast appeal about medical care,*

   We must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

You must make a request for review by an Administrative Law Judge in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. The deadline may be extended for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you receive from the independent review organization. The Administrative

Law Judge will not review the appeal if the dollar value of the medical care does not meet the minimum requirement provided in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. During this review, you may present evidence, review the record, and be represented by counsel.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

We must pay for, authorize, or provide the service you have asked for within 60 days from the date we receive notice of the decision

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4: Your case may be reviewed by the Medicare Appeals Council

This Council will first decide whether to review your case

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you or Health Net may request a review by a Federal Court Judge (Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

We must pay for, authorize, or provide the medical service you have asked for within 60 days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Appeal Level 5), so long as the dollar value of the contested benefit meets the minimum requirement provided in the Medicare Appeals Council's decision. If the dollar value is less than the minimum requirement, the Council's decision is final.

If the Council decides against you

If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you or we have the right to continue your appeal by asking a Federal Court

Judge to review the case (Appeal Level 5). If the value is less than the minimum requirement, the Council's decision is final and you may not take the appeal any further.

Appeal Level 5: Your case may go to a Federal Court

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount meets the minimum requirement provided in the Medicare Appeals Council's decision, you or we may ask a Federal Court Judge to review the case.

How soon will the judge make a decision?

The Federal judiciary controls the timing of any decision. The judge's decision is final and you may not take the appeal any further.

PART 2. COMPLAINTS (APPEALS) IF YOU THINK YOU ARE BEING DISCHARGED FROM THE HOSPITAL TOO SOON

When you are hospitalized, you have the right to get all the hospital care covered by Seniority Plus that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your "discharge date") is based on when your stay in the hospital is no longer Medically Necessary. This part of Section 11 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

When you are admitted to the hospital, someone at the hospital should give you a notice called the *Important Message from Medicare*. This notice explains:

- Your right to get all Medically Necessary hospital services covered.
- Your right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay and who will pay for it.
- That your doctor or the hospital may arrange for services you will need after you leave the hospital.
- Your right to appeal a discharge decision.

Review of your hospital discharge by Lumetra (Quality Improvement Organization – QIO)

If you think that you are being discharged too soon, ask your health plan to give you a notice called the *Notice of Discharge & Medicare Appeal Rights*. This notice will tell you:

- Why you are being discharged.
- The date that we will stop covering your hospital stay (stop paying our share of your hospital costs).
- What you can do if you think you are being discharged too soon.
- Who to contact for help.

You (or your representative) may be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital – it only means that you received the notice. If you do not get the notice after you have said that you think you are being discharged too soon, ask for it immediately.

You have the right by law to ask for a review of your discharge date. As explained in the *Notice of Discharge & Medicare Appeal Rights*, if you act quickly, you can ask an outside agency called Lumetra to review whether your discharge is medically appropriate.

What is the "Quality Improvement Organization"?

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of Health Net or your hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In California, the QIO is called Lumetra. The doctors and other health experts in Lumetra review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. Section 1 tells how to contact Lumetra.

Getting a Lumetra review of your hospital discharge

If you want to have your discharge reviewed, you must act quickly to contact Lumetra. The *Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of Lumetra and tells you what you must do.

- You must ask Lumetra for a **"fast review"** of whether you are ready to leave the hospital. This "fast review" is also called a "fast appeal" because you are appealing the discharge date that has been set for you.

- You must be sure that you have made your request to Lumetra **no later than noon** on the first working day after you are given written notice that you are being discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself, while you wait to get the decision from Lumetra (see below).

If Lumetra reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. Lumetra will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision

What happens if Lumetra decides in your favor?

- If Lumetra agrees with you, we will continue to cover your hospital stay for as long as it is Medically Necessary.

What happens if Lumetra denies your request?

- If Lumetra decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the day after Lumetra gives you its decision.

What if you do not ask Lumetra for a review by the deadline?

You still have another option: asking* Health Net *for a "fast appeal" of your discharge

If you do not ask Lumetra for a fast review of your discharge by the deadline, you can ask us for a "fast appeal" of your discharge. How to ask us for a fast appeal is covered in Part 1 of this section.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as it is Medically Necessary.
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date (unless the independent review organization overturns our decision).

PART 3. COMPLAINTS (APPEALS) IF YOU THINK YOUR COVERAGE FOR SNF, HOME HEALTH OR COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES IS ENDING TOO SOON

When you are a patient in a SNF, Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by Seniority Plus that is necessary to diagnose and treat your illness or injury. The day we end your SNF, HHA or CORF coverage is based on when your stay is no longer Medically Necessary. This part explains what to do if you believe that your coverage is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

If we decide to end our coverage for your SNF, HHA, or CORF services, you will get written notice either from us or your provider at least 2 calendar days before your coverage ends. You (or your representative) will be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received the notice.

How to get a review of your coverage by Lumetra (Quality Improvement Organization – QIO)

You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from us or your provider, you can ask Lumetra to do an independent review of whether it is medically appropriate to terminate your coverage.

How soon do you have to ask Lumetra to review your coverage?

If you want to appeal the termination of your coverage, you must quickly contact Lumetra. The written notice you got from us or your provider gives the name and telephone number of Lumetra and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must make your request **no later than noon** of the day after you get the notice.
- If you get the notice and you have more than 2 days before your coverage ends, you must make your request **no later than noon** of the day before the date that your Medicare coverage ends.

What will happen during the review?

Lumetra will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. Lumetra will also look at your medical information, talk to your doctor, and review other information that we have given to Lumetra. You and Lumetra will each get a copy of our explanation about why we believe that your services should end.

After reviewing all the information, Lumetra will decide whether it is medically appropriate to terminate your coverage on the date that has been set for you. Lumetra will make this decision within one full day after it receives the information it needs to make a decision.

What happens if Lumetra decides in your favor?

If Lumetra agrees with you, then we will continue to cover your SNF, HHA or CORF services for as long as Medically Necessary.

What happens if Lumetra denies your request?

If Lumetra decides that our decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, HHA or CORF charges after the termination date on the advance notice you got from us or your provider. Neither Original Medicare nor Seniority Plus will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability.

What if you do not ask Lumetra for a review by the deadline?

You still have another option: asking Health Net for a "fast appeal" of your discharge.

If you do not ask Lumetra for a fast appeal of your coverage termination by the deadline, you can ask us for a fast appeal. How to ask us for a fast appeal is covered in Part 1 of this section.

If you ask us for a fast appeal of your termination and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you receive past your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to continue to get your services covered, we will continue to cover your care for as long as Medically Necessary.

- If we decide that you should not have continued getting your services covered, we will not cover any care you received after the termination date.

Section 12 Appeals and grievances: What to do if you have complaints about your Part D prescription drug benefits

What to do if you have complaints

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call Member Services at the number listed in Section 1.

Please note that section 12 addresses complaints about your Part D prescription drug benefits. If you have complaints about your MA benefits, you must follow the rules outlined in Section 11.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a Plan Member. The Medicare program has helped set the rules about what you need to do to make a complaint and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from Seniority Plus or penalized in any way if you make a complaint.

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint. The following section briefly discusses grievances, coverage determinations, and appeals.

What is a grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with Seniority Plus or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy. For more information about grievances, including how to file a grievance, see Section 10.

What is a coverage determination?

Whenever you ask for a Part D prescription drug benefit, the first step is called requesting a coverage determination. If your doctor or pharmacist tells you that a certain prescription drug is not covered, **you must contact us if you want to request a coverage determination.** When we make a coverage determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. You have the right to ask us for an "exception," which is a type of coverage determination, if you believe you need a drug that is not